TTO & SELF-ADMINISTRATION PRESCRIPTION

HOSPITAL NAME AND ADDRESS	*PATIENT IDENTIFIER*
	INITIALS NHS NUMBER

NAME		DOB	

Please dispense the following medication for the above individual who is an in-patient at this establishment according to the following dosage schedule (NB. STRIKE THROUGH UNUSED SECTIONS):

Medicine name / strength / form	Dose & Frequency	Please circle TIME of administration (ensuring correct placement)	Quantity received	Received by : Sign and date
		MORN / LUN / TEA / BED		
		MORN / LUN / TEA / BED		
		MORN / LUN / TEA / BED		
		MORN / LUN / TEA / BED		
		MORN / LUN / TEA / BED		
		MORN / LUN / TEA / BED		
		MORN / LUN / TEA / BED		
		MORN / LUN / TEA / BED		
		MORN / LUN / TEA / BED		

⇩ **COMPLETE ONE SECTION BELOW EITHER- TTO SECTION (LEAVE PACK) OR SELF-ADMINISTRATION PACK** ⇩

TTO's Required		
TTO medicines to commence:	**Day/date:**	**Time:**
TTO medicines to finish on:	**Day/date:**	**Time:**

Self-Medication Packs Required (✓ relevant box)		
Stage 2 (daily packs)	**Stage 3** (3/4 day packs)	**Stage 4** (weekly packs)
State number of weeks medication needed here: ⇨		

If lithium is prescribed on this form, please supply the associated lithium form

Please repeat this prescription up to five times.

MEDICAL SIGNATURE		*QUALIFICATIONS*		*GMC NO*	
PRINT NAME		*DATE*			

1. **Email encrypted copy to dispensary@speedshealthcare.co.uk**
2. **Copy this form and retain as proof of ordering.**
   Post off original form immediately, using pre-paid envelopes to: *Speeds Healthcare, One Lakeside, Chester, CH4 9QT*

EMAILED BY		*DATE & TIME SENT*	

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